DISCUSSION*

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"We talk about the interests of the medical profession, the interests of the hospitals, the interests of the nursing homes; but above all else the whole of the health care system exists for one person and that's the individual who needs it."

Those are, of course, David Axelrod's words. Vicki Zeldin has spent the last several months assembling a video on the legacy of David Axelrod that I hope you all got a chance to see today. The quote I just offered is prominently featured—in response to an interviewer with AARP in 1990. While I don't believe I had heard that exact response until seeing the video, it captured the principle expressed by the Commissioner many times and in many ways—and it is the principle on which our office has operated for the last twelve years.

My tenure with the Department began at approximately the same time that David became Commissioner. And my succession to the Director of Health Systems Management reflected, paradoxically, or probably understandably, the nearly exclusive focus of the health care delivery system on financial matters at that time. I don't believe anyone in the Department knew better than I the frustration David felt in those initial years by the lack of attention given to, or interest in, issues of quality of care. Picture the Commissioner you all know now—David the physician—speaking at association or trustee gatherings for probably three years running about fiscal or capital issues—certainly the issues of the day—without having the opportunity to address the need for quality improvement or even seeing it on an agenda.

That is not to say that we didn't have the chance to deal with individual providers, or to confront individual facility problems. A series of incidents in the early '80s certainly helped focus the Commissioner's determination to

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expand our regulatory efforts and, more importantly, to press to elevate the pursuit of quality care to the first priority on our agenda. What seemed like interminably slow progress then, but appears in retrospect to be substantial advancement:

- we succeeded in getting authority and building the capacity for our own comprehensive survey process for hospitals;
- we added an incident reporting system, designed foremost to help hospitals focus their internal quality assurance efforts;
- we continued to improve our ability to measure outcomes in nursing homes;
- we developed a capacity to survey quality of care in home care and ambulatory care industries;
- we recodified the hospital code, attempting to shift the focus to outcome rather than process measures, and including the most notable changes to improve resident training conditions and reemphasizing responsibilities of attending physicians for the supervision of residents and patient care;
- we recodified the nursing home code, enhancing the rights of the infirm elderly to be served with dignity; and
- we developed an enhanced capacity to analyze and report in publicly consumable fashion on the quality of care in hospitals.

To simply catalogue these events and the many others I've skipped in between does not do justice to the nature of the debate over our regulatory agenda, its roots or the complex interrelationship of its component parts. Critics have been successful in raising the spectre of "micromanagement" in characterizing the Department's efforts. I am surely biased in my view, but that value laden word greatly oversimplifies the evolution of a regulatory system which seeks to protect the public the best way we know how.

The development of our own hospital survey capacity and institution of an incident reporting process followed the recognition that hospital boards of the early '80s spent little or no time looking at the quality of care delivered in their hospitals until something went wrong, and that those boards were without tools to know where to start when they wanted to look.

By the time we obtained the authority to mount an independent survey process, but well before we were capable of performing surveys, the Commissioner had already moved on to the need for more substantive restructuring of the delivery of care in hospitals, including the evolving theories of quality control, now known as total quality management or continuous quality improvement. I assure you we all read Edward Demming's "fourteen points" and "seven deadly diseases," and more than a few times the industry chiefs

heard it told that they were mired in a nineteenth century health care delivery model. While David was anxious to see the promised benefits of continuous quality improvement as an internal management technique in the hospital industry, I don't believe he saw it as a substitute for our regulatory review activities. One is a potential tool to help management do its job, the other to help assure the public that there is someone also there watching out for their welfare.

More important to the commissioner was the desire to empower the public with the capacity to make as informed judgments about the health care delivery system as he might make. I'm sure David saw this as potentially the most effective regulatory tool. He recognized that no single mechanism was likely to move providers—either individual practitioners or institutional providers—as an informed and demanding public. We began to develop our analytical capacity to help focus our surveillance efforts—both for hospitals and nursing homes. That has evolved to studies of cardiac mortality, highlighting the performance of individual hospitals and the contribution of individual surgeons and surgical volume on outcome and current projects to measure performance in neonatal intensive care units and trauma services. With the objective of better informing the public, however, comes the added responsibility to understand the power of information and the potential for its misuse. I can't tell you how long or how many times we discussed the release of the cardiac data to insure that it wouldn't be misinterpreted. But in the final analysis the choices are reasonably straightforward—with the repository of information we collect, can you choose not to mine it? When you develop information that you would use yourself to make health care choices, can you keep it for use by a select few? Again, we are guided in our choices by the principle that the system exists for the benefit of the public that needs it.

Throughout the past decade, the record also shows that we have not shied away from using the regulatory process to promote standards of performance when needed. From triplicate prescriptions for benzodiazapines which were prone to abuse, to limitation on residents, working hours, to reminding physicians of their responsibility for their supervision of patients even when residents are there to help, to responding to the demands of the AIDS epidemic, including even now the standards for HIV infected health care workers. It would be too glib to say each of these regulatory endeavors were undertaken only after attempts at voluntary change failed. The complexity of policy development, the need to respond quickly and decisively in some instances, do not permit easy generalizations. But regulations were not, are

not, pursued for regulation's sake. They were and are pursued to fill a need or to fill a void without regard for the potential obstacles or opposition.

The principles of accountability—for governing boards and practitioners—equal access, as a measure of quality health care, and the need to empower the public with the capacity to make responsible decisions about the care they need, are the principles which have guided our regulatory mission, our regulatory agenda. I believe these principles served us and the public well over the past decade, and we are committed to maintaining these principles, this mission, as we look forward to the next decade. This day's agenda is filled with important components of a rational and responsible health care system for the state's residents. Each component is well underway, but a great deal of work remains to be done. We, in the Department, have the will, and are committed to provide the energy to see them through.

On a more personal note, I expect the common perception is that David would be a tough boss. Nothing could be further from the truth. Eighty staff got up at 4:00 a.m. today to take buses down here. And we could have filled this auditorium three times over with the staff who wanted to come. One of David's most important legacies is that he attracted a staff who are, as you might expect, highly motivated over-achievers with high personal standards of performance. The fact that David set the highest standards and chose to lead by example, only served to reinforce us when the demands seemed endless. What would have made work difficult is uncertainty over the principles that should guide the office. There was never any uncertainty. In the Commissioner's words, "the health care system exists for one person and that's the individual who needs it." What that meant is that if you had a reasonable sense of what was right—what was best for the public good—it could guide you to act in confidence. David's principles guided me, guided us, during the last 12 years and they form the foundation to guide me, guide us, into the future.